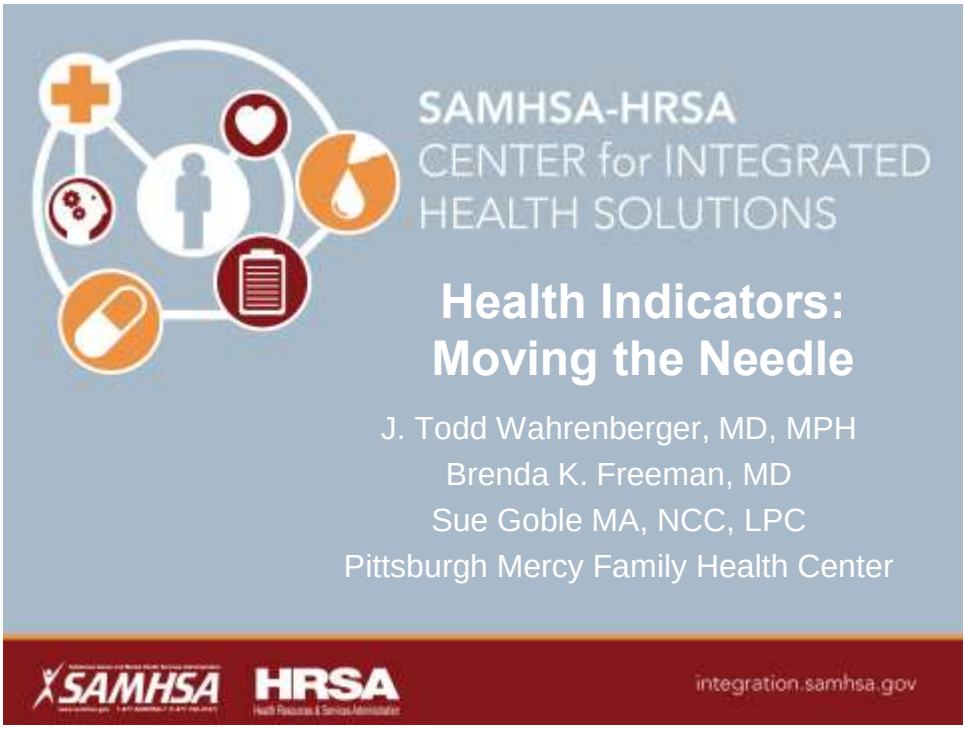

Agenda

- These modules are intended for PCPs working in public mental health settings, to deal with the health disparity experienced by patients with (SMI).
- Goal: to help facilitate their work in this environment, which may be unfamiliar to many PCPs, so they can best serve this population of patients.
  - ❑ Understanding the Target Population
  - ❑ Building an Integrated Care Team
  - ❑ Moving the Dial

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Understanding the Target Population

What do we know about the SMI Population?

1. The premature mortality seen in the SMI population is:	• 25-30 years • 20-25 years • 15-20 years • 10-15 years
2. What percent of illness contributing to this early mortality is preventable?	• 20% • 40% • 60% • 80%
3. What are the leading illnesses that contribute?	• Cardiovascular • Infectious disease • Cancers • All of the Above

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Different models must be tested – the cost of suffering and doing nothing is unacceptable."

Vieweg, et al., American Journal of Medicine. March 2012

Why primary care services in mental health?

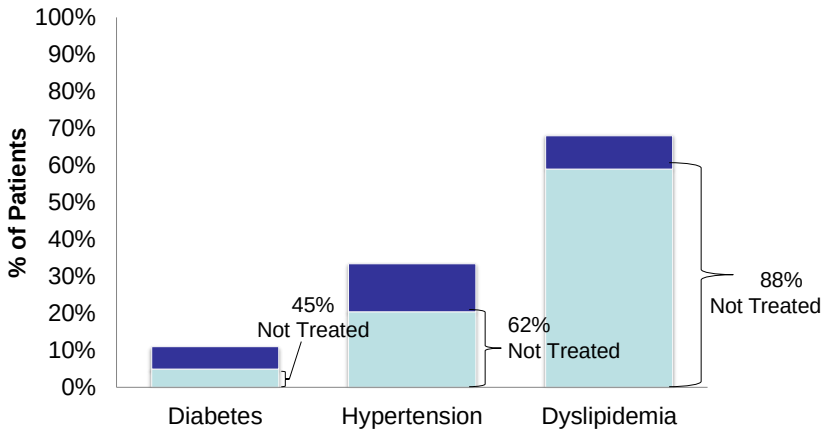
- High rates of physical illness in severely mentally ill
- Premature mortality
- Patients with mental illness receive a lower quality of care
- High cost of physically ill with mental illness
- Access problems

Cardiovascular Disease is Primary Cause of Death in Persons with Mental Illness

Cardiovascular Disease Risk Factors		
Modifiable Risk Factors	Estimated Prevalence (%) and Relative Risk (RR)	
	Schizophrenia	Bipolar disorder
Metabolic syndrome	37-60%, 2-3 RR	30-49%, 2-3 RR
Dyslipidemia	25-69%, 5 RR	23-38%, 3 RR
Hypertension	19-58%, 2-3 RR	35-61%, 2-3 RR
Diabetes mellitus	10-15%, 2-3 RR	8-17%, 1.5-3 RR
Smoking	50-80%, 2-3 RR	54-68%, 2-3 RR
Obesity	45-55%, 1.5-2 RR	21-49%, 1-2 RR

De Hert M, et al. World Psychiatry. 2011 Feb; 10(1): 52–77

Disparities: Rates of Non-treatment



De Hert M, et al. World Psychiatry. 2011 Feb; 10(1): 52–77

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Selected adverse effects of antipsychotic medications for schizophrenia

	Weight gain/diabetes mellitus	EPS/TD	Prolactin elevation	Sedation	Anti-cholinergic side effects	Orthostatic hypotension	QTc prolongation
First generation agents							
Chlorpromazine	+++	+	++	+++	+++	+++	+
Fluphenazine	+	+++	+++	+	-	-	ND
Haloperidol	+	+++	+++	++	-	-	+
Loxapine	++	++	++	++	+	+	+
Perphenazine	++	++	++	++	-	-	ND
Thiothixene	++	+++	++	+	-	+	+
Trifluoperazine	++	+++	++	+	-	+	ND
Second generation agents							
Aripiprazole	-	+	-	+	-	-	-
Asenapine	+	+	++	++	-	+	+
Clozapine**	+++	-	-	+++	+++	+++	+
Iloperidone	++	+	-	+	+	+++	++
Lurasidone	-	+	+	++	-	+	-
Olanzapine*	+++	+	-	++	++	+	+
Paliperidone	++	++	+++	+	-	++	+
Quetiapine*	++	-	-	++	+	++	++
Risperidone	++	++	+++	+	-	++	+
Ziprasidone	-	+	+	+	-	+	++

Adverse effects may be dose dependent.
EPS: extrapyramidal symptoms; TD: tardive dyskinesia; ND: no data.
* Clozapine also causes granulocytopenia or agranulocytosis in about 1 percent of patients requiring regular blood cell count monitoring.
• Clozapine, olanzapine, and quetiapine are also associated with dyslipidemias and decreased insulin sensitivity.

Monitoring Protocol For Patients on Atypical Antipsychotics							
Assessment Parameter	Cut-offs	Baseline	4 wks	8 wks	12 wks	Quarterly	Annually
Medical and Family History, Including CVD	n/a	x					
Weight, BMI (kg/m^2)	>7% gain over baseline or >25 kg/m^2	x	x	x	x	x	
Waist Circumference	Men: 40 in., Women: 35 in.	x					x
Hemoglobin A1c	Pre-DM: >5.7%, DM: >6.5%	x			x		x
Random Plasma Glucose	Pre-DM: > 140 mg/dL, DM: > 200 mg/dL	x			x		x
Blood Pressure	>140/90 mmHg	x			x		x
Non-Fasting TC and HDL	Non-HDL >220mg/dL; or 10-yr risk > 7.5%	x			x		x

Building an Integrated Care Team

Location + Collaboration = Integration

Integration

Minimal Collaboration	Basic Collaboration from a Distance	Basic Collaboration Onsite	Close Collaboration/ Partly Integrated	Fully Integrated
Separate systems	Separate systems	Separate systems	Some shared systems	Shared systems and facilities in seamless bio-psychosocial web
Separate facilities	Separate facilities	Same facilities	Same facilities	Consumers and providers have same expectations of system(s)
Communication is rare	Periodic focused communication; most written	Regular communication, occasionally face-to-face	Face-to-Face consultation; coordinated treatment plans	In-depth appreciation of roles and culture
Little appreciation of each other's culture	View each other as outside resources	Some appreciation of each other's role and general sense of large picture	Basic appreciation of each other's role and cultures	Collaborative routines are regular and smooth
	Little understanding of each other's culture or sharing of influence	Mental health usually has more influence	Collaborative routines difficult; time and operation barriers	Conscious influence sharing based on situation and expertise
			Influence sharing	
"Nobody knows my name. Who are you?"	"I help your consumers."	"I am your consultant."	"We are a team in the care of consumers"	"Together, we teach others how to be a team in care of consumers and design a care system."

Where do you fall?

Barriers to Providing Primary Care to SMI Population

Cultural
- Mental health staff and patients not used to incorporating primary care as part of job
- Psychiatric staff feel time pressure to address screening, vital signs and may feel "out of scope" for specialty

Financial
- Limited funding
- Different billing structures
- High no show rates, takes extra time
- Psychiatric providers not provided resources such as Medical Assistants

Motivational
- Lack of perceived need for care
- Lack of motivation as part of negative symptoms of schizophrenia

Organizational
- Devoting space, time, and money
- Specialists do not cross boundaries
- Different languages
- Behavioral health EHRs may lack capacity to track physical health indicators
- Not perceived as part of the Mission

Physical Location
- Proximity is crucial to success
- Same building is best
- Space limitations.

Working with Psychiatric Providers

Primary Care	Behavioral Health
✓ Continuity is goal	✓ Termination is goal "close the chart"
✓ No stigma	✓ Stigma common
✓ Data shared	✓ Data private
✓ Large panels	✓ Small panels
✓ Flexible scheduling	✓ Fixed scheduling
✓ Fast paced	✓ Slower pace
✓ Time is independent	✓ Time is dependent, "50 min hour"
✓ Flexible boundaries	✓ Firm boundaries
✓ Treatment external (labs, procedures)	✓ Relationship with provider IS treatment
✓ Patient not responsible for illness	✓ Patient responsible for participating in treatment

"You're killing me with those meds…"

Build a relationship with the Psychiatry staff

- Establish lines of communication with the extended BH treatment team
- Understand the importance of Psychopharmacology
- Stabilizing mental illness to treat the medical condition
- Understand the importance of patient goals and let that drive the treatment decision
- Harm reduction strategies – taking a page out of the APA

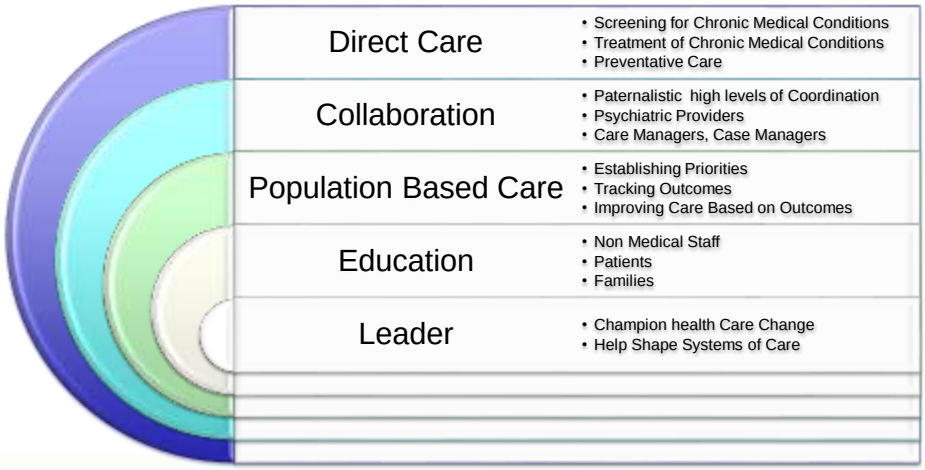
Case Experience…

45 year old male with progressing copd with schizophrenia and active psychosis considering smoking cessation. Patient is on Clozaril.

30 y/o woman with Bipolar, recent incarceration, 10 months sober from heroin, cocaine, alcohol.

46 y/o male just released from 2 yrs in prison with 40lb weight gain HbA1c 6.1, on Seroquel

Roles for PCPs in Behavioral Health Settings



Building the Team

LCSW

Case Manager

Psychiatric Providers

Nurse

Addiction Specialist

Admin

Psychologist

Peers

Primary Care Doctor

Pharmacist

Service Dog

Core Principles of Collaborative Care

Patient Centered Team Care

- Effective collaboration between PCPs and Behavioral Health Providers
- Nurses, social workers, psychologist, peers, pharmacists, medical assistants, and licensed therapists are all equally important to the team

Population Based Care

- Tracking behavioral health patients in registries: no ones falls through the cracks

Measurement Based Treatment to Target

- Measurable treatment goals clearly defined and tracked for each patient
- Treatments are actively changed until the clinical goals are achieved

Evidence Based Care

- Treatments with credible research evidence to support their efficacy in treating the target condition

Accountable Care

- Providers are accountable and reimbursed for quality of care and clinical outcomes

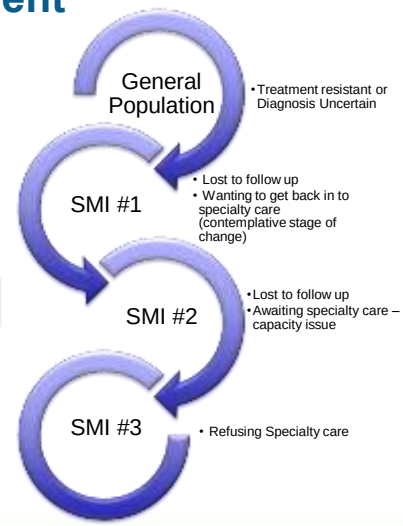
AIMS 2015

Team Based Population Management

Our Team

- Primary Care Provider
- Consulting Psychiatrist
- Care Manager
- Peer Support Coach
- Tobacco Cessation
- Medical Assistant
- Social Service Program

Drives our team



Team Training and Communication

- Show staff the importance of capturing health indicator data
- One pagers – Diabetes, Hypertension
- Share latest articles/websites tracking progress
- Case to Care Training
- Track organizational progress
  - Barriers to enrollment
  - Barriers to capturing data
  - PDSA Workflow Redesigns

Case Experience…

44 yo, depression, metabolic syndrome, mentally stable (on invega), referred from BH, meeting with DM educator

Moving the Dial

Opportunities for Change

How Many Interactions with Patients in Different Settings During a Year?	
Primary Care	4-6
Mental Health Settings:	
Psychiatrist	4
Nurse	4
Case Manager	20
Therapist/Crisis	5
Peer Specialists	5

30-40 opportunities a year!?

Monitoring and Treatment Protocols

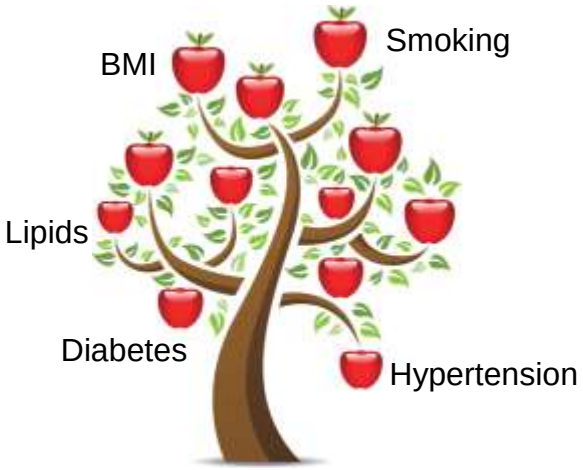
Physical Health checks should focus on monitoring:

- ❑ Weight Gain and Obesity (BMI, WC)
- ❑ Blood Pressure
- ❑ Fasting Blood Glucose
- ❑ Lipid Panel
- ❑ Use of tobacco, CO level
- ❑ Use of alcohol and other substances
- ❑ Activity Level and Exercise
- ❑ Dietary Intake
- ❑ Prolactin levels (if indicated)
- ❑ Cardiovascular Disease
- ❑ Dental health
- ❑ Liver Function Test

Standing Protocols

- ❑ Tobacco Cessation
- ❑ Point of Care Testing
- ❑ In office lab
- ❑ WHAM
- ❑ Diabetes Education Groups
- ❑ Medication Reconciliation

Low Hanging Fruit



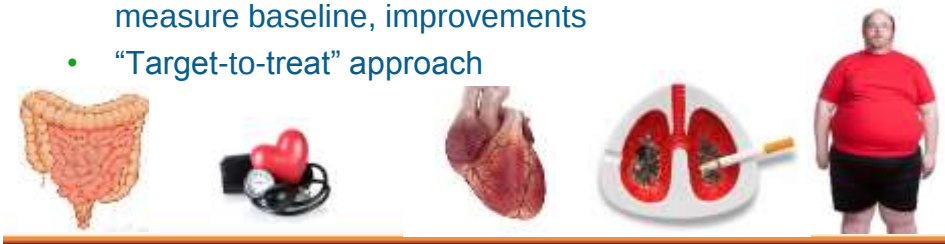
"Force Multiplier Effect"

Health Behavior Change

- Behavior change is the expertise of the psychiatric world
- Motivational Interviewing, Health Action Model

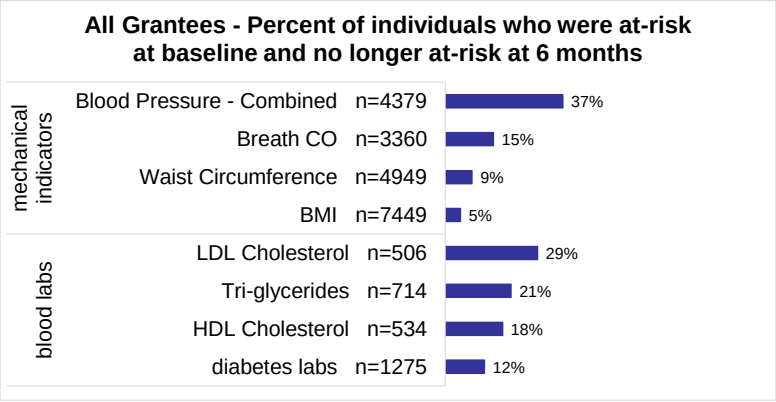
Physical Health Indicators

- Using mechanical health indicators and blood labs to measure baseline, improvements
- "Target-to-treat" approach



Effects of Interventions to Reduce Risks Factors

***Small* changes have a Significant Impact**

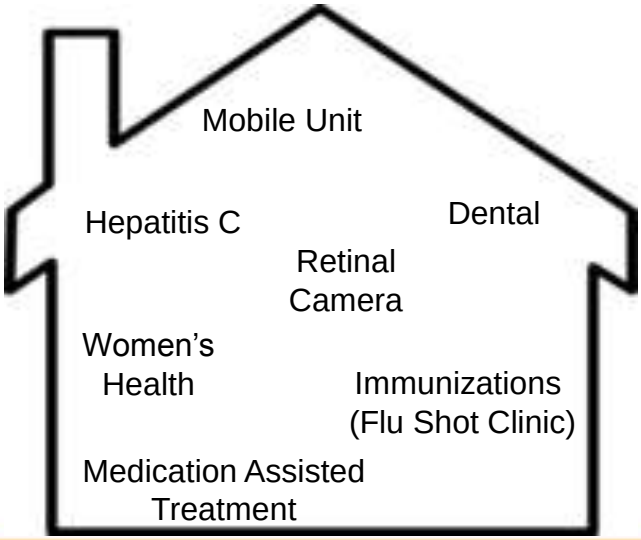


"In God we trust, all others bring data" **W. Edwards Deming**

Engagement & Treatment Adherence

- KISS
- Daily, weekly, monthly check-ins
- Mobile Meds
  - One week at a time(don't have too much to lose)
- ACCESS - onsite labs and pharmacy
- Flywheel Principle
- Engaging with the "right" team member
- HOPE

Utilization of Specialty Clinics



$$\frac{(SBIRT + CDM + MAT) \times (C + DNH)}{(E \times IATC) \times T^2} = IPO$$

(SBIRT + Chronic Disease Management + Medication Assisted Treatment) x (Competence + Do No Harm)/(Engagement X Immediate Access to Care) x Technology = Improved patient Outcomes

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Case Experience

58 yo Female, severe somatization disorder, Hepatitis C, seen weekly in PCP office for reassurance.

Sharing Experiences